CHALLENGES OF IMPLEMENTING ADHERENCE PSYCHOLOGY IN OPHTHALMOLOGY CLINICAL PRACTICE

Interview with Steven R. Hahn, MD
Conducted by David S. Friedman, MD, MPH, PhD

Steven R. Hahn, MD, is a colleague of mine, and he has a unique background to discuss the topic of adherence. Dr Hahn is a Professor of Clinical Medicine and Instructor of Psychiatry at Albert Einstein College of Medicine of Yeshiva University in Bronx, New York. He is also Director of MedIntel On-Call, a medical communications consulting company specializing in physician and patient behavior change and research in behavioral, interpersonal, and communication issues in medical care. After completing residency training in internal medicine at Montefiore Medical Center, he pursued his interest in these issues with a fellowship in behavioral science for primary care medicine at Bronx Psychiatric Center of Albert Einstein College of Medicine. He continues to conduct research and provide consultation on the integration of mental health, central nervous system disorders, and behavioral treatment in general and specialty medical care, with special interest in adherence to medical treatment, depression, and the difficult doctor-patient relationship.

In the following interview, I spoke with Dr Hahn about adherence issues with glaucoma therapy, in light of his work on the Glaucoma Adherence and Persistency Study. He provides unique insights into the psychology of adherence.

Dr Friedman: Studies seem to indicate that ophthalmologists are not particularly good at recognizing which patients are poorly adherent to topical therapy. Based on your experience, is this true in other disease areas?

Dr Hahn: In brief, yes. As we discussed in our program, the concerns that drive patients to conceal non-adherence are basic to human nature and observed across all therapeutic areas. Physicians feel good when they are caring for a “good patient”; they want to believe that they are the kind of doctor that patients would not want to deceive, thus, to some extent physicians blame themselves when their patients are nonadherent. Therefore, there is a tendency for physicians to collude with their patients’ presentation of themselves as perfectly adherent, and as a result, difficulty in detecting nonadherence is found in all medical disciplines and is in no way unique to ophthalmology.

Dr Friedman: You suggest asking the patient to describe how he takes his medication, instead of simply asking if he is taking it. How should a physician respond to a patient who might become defensive with this approach?

Dr Hahn: Most patients are not defensive about responding to this question. However, the best strategy is to ask in such a way that the desired “shared-decision making” process is explicitly invoked, as in:

**Doctor:** Just to make sure we’re on the same page, tell me how you’re taking your medications.

If worse comes to worst, and you forgot to phrase the question in this way, you can always apologize for the perceived offense and move on to the normalizing-and-universalizing second step to explain why you asked the question:
Doctor: Tell me how you've been taking your medicines.
Patient: Just like you told me to, doctor. Do you think I'm not smart enough to understand how to take my medicine?
Doctor: No, of course not, but it can be difficult for anyone to keep all the details straight, and I want to make sure that between you, me, and the pharmacy, we are all on the same page.

If you think that the defensive response is due to concern about revealing a literacy problem or nonadherence that actually is due to confusion about the regimen, then explicitly universalizing difficulty with medication names may be a helpful addition, as in, "I just want to make sure, because a lot of people have difficulty with medicine names and written medication directions."

Dr Friedman: We see in the second case study (Mr Carpenter) that his wife is with him in the office visit and essentially “tells on him” about his poor adherence. How does the physician work with a spouse or family member, without getting drawn into any family dynamics or controversies?

Dr Hahn: An interesting question. First, remember that your primary obligation is to the patient (even when your sympathies may lie elsewhere), and you have the moral authority to direct attention to the patient's medical issues. It will also help to reframe any family member's negative expressions as positive concern and to empower the patient by "giving the floor" back to him:

Patient’s Family Member: Doctor, he really hasn't been taking care of himself the way you told him to. I just don't know what to do. I tell him over and over again, but he just doesn't listen. I think he's going to make me crazy!
Doctor: To Family Member—I really appreciate your concern about your husband's health. [Reframe as positive concern] We can all work together to address these problems. [Invoke the high ground and make shared-decision making explicit]. To Patient—Tell me about your concerns and perspective on this.

Dr Friedman: You mentioned that these strategies for detecting and addressing adherence can take less than 5 minutes, but some interactions surely will take more time than that.

Dr Hahn: It is actually pretty remarkable how little time this agenda requires. Furthermore, we are suggesting that the encounter will take about 5 minutes when there is a problem; it will be much shorter when there is no problem. Most importantly, this is an intervention for early in the course of care with a patient. It is not something that will need to be done repetitively; your patients will quickly become trained for your approach to the adherence interview and will be prepared. We know that ophthalmologists spend 8 or so minutes face-to-face with their patients during an average visit and spend half that time talking about glaucoma. Thus, the time we think it will take to employ these techniques is entirely consistent with current practice. If nonadherence is a problem, there is very little else that will be more important to deal with. With those patients who are going to take more time, the odds are that those patients will take more of your time no matter what the agenda is.

Dr Friedman: How much of this patient interaction do you recommend we can comfortably leave to our physician extenders? What type of training would they need to adequately address the psychology of the nonadherence?

Dr Hahn: It depends. There is no question in my mind that the physician has to champion this agenda if it is to be successful. I also think that once you have climbed the real but relatively brief learning curve to mastery of these techniques, you will be a good judge of your staff’s competency. Structured decision support tools are available to guide nonphysician clinicians in basic assessment of adherence barriers and in delivering patient education and skills training to lower adherence barriers. The added value of investing in establishing protocols and providing some training will become more obvious to the clinician who uses these techniques to systematically detect nonadherence, because the magnitude of the problem will then be evident and the return on investment will be more obvious. At the very least, physicians should educate anyone who is involved in medication inventory dialogue with the patient to avoid the kind of closed-ended question that invites a premature and untruthful declaration of perfect adherence.

Dr Friedman: You mentioned the Stages of Readiness for Change model and meeting the patients “where they are,” but some doctors simply
do not feel comfortable with this level of patient interaction. How do you advise them?

Dr Hahn: Actually I think that doctors are already using the stages-of-change concept more than they realize. Although there is still a tendency to talk to patients about what they should be doing, even when you know they are not yet committed, it is also true that when the lack of concern of “pre-contemplation” or the ambivalence of “contemplation” is detected, most doctors will address it instinctively. The problem is that when patients act as though they are in agreement with you, the truth is they may still be in a concealed state of precontemplation or contemplation. Therefore, the new message is to ask about “concern” and you will detect precontemplation and contemplation in patients who look like they are already past decision or determination and ready for action.

Dr Friedman: With all the misinformation on the Internet, is it really so bad to have doctor-dependent learners?

Dr Hahn: The common (and politically correct) wisdom dictates that an “activated” patient who is committed to playing an active role in self-management is supposed to have the best outcomes because he will make a more substantial contribution to self-care. However, the activated patient may reach conclusions, based on the information he has encountered, that are at odds with those of his doctor. The “therapeutic decision” model of adherence behavior posits that patients can be stratified into 3 groups. One of these groups is consistent with our doctor-dependent learners. At the opposite extreme are those who have strongly held beliefs, whether well founded or not, who will make up their own minds after considering their doctor’s “recommendations.” We could call these patients “self-directed.” The third, intermediate group of “collaborative learners” includes patients who engage in true, shared-decision making. These are actually the ideal patients who will be most likely to reveal problems they are having with treatment, expecting that the doctor will accept their concerns as legitimate and help them address them. The problem with doctor-dependent learners is that, although they will initially follow their physicians anywhere on faith alone, they tend to crumble with the first obstacle. They are not committed to acquiring a depth of understanding or determination to engage collaboratively with their physicians in addressing problems with treatment, which will almost inevitably arise in the course of treating a chronic disease such as glaucoma.